MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

16130

Reg. Dist. No. 166

1. PLACE OF DEATH:
County Garrett
City or town Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 Mo
Hospital, institution, or street address where death occurred:
Kisers Nursing Home
How long in hospital or institution? 18 Mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ----

3.(a) FULL NAME
Charles Clark Adams

3.(b) Social Security Number
215-05-2204

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife ----
6.(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) February 10, 1877

8. AGE: Years	Months	Days	If less than one day
68	7	25	....hrs. ....min.

9. Birthplace Allegheny Co., Md.
(Town, county, and state)
10. Usual occupation Blacksmith and Machinest
11. Industry or business Coal mines
FATHER 12. Name James W. Adams
13. Birthplace Clear Spring, Md.
MOTHER 14. Maiden name Geneva McCune
15. Birthplace Allegheny Co., Pa.
16. Informant Harold Adams
Address Vindex, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof October 7, 1945 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.
18. Funeral director Herbert C. Leighton
Address Oakland, Md.
19. 10/6/ 19 45 Julia Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1945 at 5:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-14-37 to 10-3-45 10-5-45 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Dilated Heart and Atherioscleresis	15 yrs
Heart attack	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

23. SIGNATURE Herbert C. Leighton M. D. or other
Address Oakland, Maryland. Date signed 6-10-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

16131

Reg. Diat. No. 66

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Crellin, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Several Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Grellin, Maryland.
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Abigail Kendall Baker.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John W. Baker. Deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 8, 1855

8. AGE: Years	Months	Days	If less than one day
90	7	2 4	..... hrs. ..... min.

9. Birthplace: Greenville Township Penn. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: John C. Kendall
13. Birthplace: Greenville Township, Penn.

MOTHER
14. Maiden name: Elizabeth Miller.
15. Birthplace: Greenville Township, Penn.

16. Informant: Mrs Homer Wright.
Address: Crellin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 6/45 (month) (day) (year)
Cemetery or crematory: Hostettler Cemetery
Location: Meyersdale, Pa.

18. Funeral director: Ensley D. Bolden
Address: Oakland, Md.

19. 10/4/45 (Date rec'd by registrar) Julia Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2d 1945 at 2:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945, to Oct 2nd 1945
and that I last saw h.. alive on ..... 19.....

Immediate cause of death	DURATION
Uraemic Myocarditis	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: M. C. Hirshbaugh M. D. or other
Address: Oakland Md Date signed: 10/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

16132

Reg. Dist. No. 166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Oakland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? - - -
Hospital, institution, or street address where death occurred: On B & O Engine moving East from Oakland, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegheny
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. D. Roberts Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Fred L. Cessna

3. (b) Social Security Number: 212-18-1330

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine Weaverling Cessna
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 19, 1907

8. AGE: Years	Months	Days	If less than one day
38	2	8	hrs. min.

9. Birthplace: Bedford Co., Pa. (Town, county, and state)
10. Usual occupation: Breakman
11. Industry or business: B & O R. R.
FATHER 12. Name: Thomas L. Cessna
13. Birthplace: Pa.
MOTHER 14. Maiden name: Jane Howsare
15. Birthplace: Pa.
16. Informant: Mrs. Catherine Cessna
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30, 1945 (month) (day) (year)
Cemetery or crematory: Rainsburg, Pa.
Location: Bedford Co.
18. Funeral director: Herbert C. Leighton
Address: Oakland, Md.
19. 10/28/ 1945 Julia Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 19 45 at 8 15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Examined after Dead 19
and that I last saw h alive on 19
Immediate cause of death: Comminuted fractures (Depressed) Occipital & parietal portions skull
Due to: Trauma Accident — DURATION
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 10/27/45
Where did injury occur? Oakland (City or town) Garrett (County) (State)
Injured at home, farm, industry, public place (where?): B.&O. R.R. tracks
Means of injury: struck head against bridge while on train Injured at work? Yes
23. SIGNATURE: J. J. Baumgartner M. D. Asst. Med. Dept. Gen. Mgr. M. D. or other
Address: Oakland Md. Date signed 10/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(93d) 10133

Reg. Diat. No. 170

1. PLACE OF DEATH:

County: Garett

City or town: Rural Near Avilton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Garett

City or town: Rural Near Avilton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Henry Steward Crowe

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lavena Crowe

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): March II I860

8. AGE: Years	Months	Days	If less than one day
85	6	28	..... hrs. ..... min.

9. Birthplace: R.D.2 Grantsville Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business: Farmer & Timber Worker

FATHER
12. Name: Henry Crowe
13. Birthplace: Not Knowen

MOTHER
14. Maiden name: Hariet Durst
15. Birthplace: Not Knowen

16. Informant: Mrs Lavena Crowe
Address: Avilton Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: IO-I2-I945
(mouth) (day) (year)

Cemetery or crematory: New Germany

Location: R.D.2 Grantsville Md

18. Funeral director: Wm. Whitelegg

Address: Grantsville Md

19. Oct 11 1945 Geo B Broadwater
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1945 at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Oct 9 1945

and that I last saw h... alive on Oct 1 1945

Immediate cause of death	DURATION
a Chronic Myocarditis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. R. Davis M.D.
M. D. or other

Address: Grantsville Date signed: Oct. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

19134

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119a)

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:
County: Garrett
City or town: Rural Near Grantsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garrett
City or town: Rural Near Grantsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Kathryn May Durst

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.): November 23 1944 (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
-	10	28	hrs. min.

9. Birthplace: Rural Near Grantsville Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Woodrow Durst
13. Birthplace: Rural Near Grantsville Md

MOTHER
14. Maiden name: Margaret Durst
15. Birthplace: Rural Near Grantsville Md

16. Informant: Ritchard Durst
Address: Grantsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-21-1945 (month) (day) (year)
Cemetery or crematory: Durst
Location: Rural Near Grantsville Md

18. Funeral director: Wm Winterberg
Address: Grantsville Md

19. Oct 20 1945 (Date rec'd by registrar) Ethel Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 19 1945 at 11:33 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 11 1945 to Oct 19 1945
and that I last saw h[illegible] alive on Oct 19 1945

Immediate cause of death	DURATION
Coronic Colitis	1 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. R. Davis M.D.
M. D. or other
Address: Grantsville Date signed: Oct 22 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1705)

CERTIFICATE OF DEATH

14135

★ Reg. Dist. No. 162

1. PLACE OF DEATH:

County: Garrett

City or town: On Rute 40 Near Grantsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Garrett

City or town: Rural N. Accident Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jacob Nelson Fasenbaker

3.(b) Social Security Number: 220-10-2877

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 23-1893

8. AGE: Years	Months	Days	If less than one day
52	2	26	hrs. min.

9. Birthplace: Rural Near Accident Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: John T. Fasenbaker

FATHER 13. Birthplace: Lonaconing Md Rural

MOTHER 14. Maiden name: Susan Durst

MOTHER 15. Birthplace: Rural Near Lonaconing Md

16. Informant: William Fasenbaker

Address: R.D. Accident Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-23-1945 (month) (day) (year)

Cemetery or crematory: Betheasda

Location: Rural Near Grantsville Md

18. Funeral director: Allen Winterberg

Address: Grantsville Md

19. Oct 22 1945 Esther Broadwater Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21 1945, at 12 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Examined after Death 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Crushing injuries to chest Wall with Punctured Lungs.	
Due to Struck by Car	
Fractured Kept talking,	
Due to fibula - Radius ulna + Ribs	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide: Accident Date of 10/21/45

Where did injury occur? Rout 40 near Grantsville Garrett Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Road

Means of injury: Struck by Car Injured at work? No.

23. SIGNATURE: E. J. Baumgartner M.D. Examining Physician
M. D. or other

Address: Oakland Md Date signed 10/21/45

Dead, med. Co.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-a)

CERTIFICATE OF DEATH

10136

Reg. Dist. No. 166

1. PLACE OF DEATH:
County: Garrett
City or town: Deer Park, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylavania County: Somerset County
City or town: Somerset Pa.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Franklin Henry Martin.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

B.(b) Name of husband or wife
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 11th 1906

8. AGE: Years	Months	Days	If less than one day
39	7	16	..... hrs. ..... min.

9. Birthplace: Somerset Pa.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Daniel C. Martin.
13. Birthplace: Pennsylavania.

MOTHER
14. Maiden name: Charlotta Kraft.
15. Birthplace: Ohio.

16. Informant: Harry Martin.
Address: Somerset, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30th/45 (month) (day) (year)
Cemetery or crematory: Somerset Cemetery.
Location: Somerset, Pa.

18. Funeral director: Emory D. Baldeen
Address: Oakland, Md.

19. 11/27/45 (Date rec'd by registrar) Julia Rowan, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Octber 27 1945, at 5-P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Hammed after death 19.....
and that I last saw h.....alive on ..... 19.....

Immediate cause of death	DURATION
Fracture of Skull	
Fracture Left Femur & Pelvis	
Due to Automobile + truck collision	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 10/27/45
Where did injury occur? Deer Park (City or town) Garrett (County) Md (State)
Injured at home, farm, industry, public place (where?) Railroad Crossing
Means of injury: Struck by locomotive Injured at work? No

23. SIGNATURE: Edgar Bennington M.D. Dept. med. Examiner
M. D. or other
Address: Oakland Md Date signed 10/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16137

Reg. Dist. No. 161

1. PLACE OF DEATH:

County: Garrett

City or town: Near Friendsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Martha V Savage

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE: Years: 82 | Months: 9 | Days: 30 | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER 12. Name: Jessie Friend

13. Birthplace: Md

MOTHER 14. Maiden name: Friend

15. Birthplace: Md

16. Informant: Webster Savage

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/4/45 (month) (day) (year)

Cemetery or crematory: Cem. Sandspring Md

Location: Sand Spring Md.

18. Funeral director: W W Savage

Address: Friendsville Md

19. 11/4 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1945, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24 1945, to Oct 31 1945

and that I last saw her alive on Oct 24 1945

Immediate cause of death	DURATION
Hemiplegia	1
Due to Cerebral Haemorrhage	9
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. B. Morrison (M. D. or other)

Address: Addison - Pa Date signed 11/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-1)

CERTIFICATE OF DEATH

10138

Reg. Dist. No. 166

1. PLACE OF DEATH:
County: Garrett County
City or town: Hutton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Hutton, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Levenia Ellen Scott.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Birt C. Scott.
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): April 29th, 1874.

8. AGE: Years	Months	Days	If less than one day
71	5	20	...hrs. ...min.

9. Birthplace: Garrett County, Md. (Town, county, and state)
10. Usual occupation: House wife.
11. Industry or business

FATHER
12. Name: Edward Wolfe.
13. Birthplace: Preston County, W. Va.

MOTHER
14. Maiden name: Annabelle Glover.
15. Birthplace: Preston County, W. Va.

16. Informant: Birt C. Scott.
Address: Hutton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 21/45 (month) (day) (year)
Cemetery or crematory: Oakland, Cemetery.
Location: Oakland, Md.

18. Funeral director: Emroy D. Baldwin
Address: Oakland, Md.

19. Oct 20 1945 (Date rec'd by registrar) Jules Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18th 1945, at 7:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1945, to ...19...
and that I last saw her alive on 6/23/45 ...19...

Immediate cause of death: Cardiac decompensation — DURATION: 4 months
Due to: Rheumatic Mitral disease and
Due to: Moderate hypertension
Other conditions: Moderate osteo arthritis
(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harold C. Miller M.D. M. D. or other
Address: Eglon, W. Va. Date signed: 10/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10139

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 931

CERTIFICATE OF DEATH

Reg. Dist. No. 166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Oakland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John G. D. Spiker.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mary Tucker Spiker
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): September 22d, 1862

8. AGE: Years	Months	Days	If less than one day
83	0	15	hrs. min.

9. Birthplace: Garrett County. (Town, county, and state)
10. Usual occupation: Retired Farmer.
11. Industry or business

FATHER
12. Name: Abraham Spiker.
13. Birthplace: Garrett County.

MOTHER
14. Maiden name: Sarah Jane Riley.
15. Birthplace: Garrett County.

16. Informant: Mrs. Mary Spiker.
Address: Oakland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10/45 (month) (day) (year)
Cemetery or crematory: Oakland Cemetery.
Location: Oakland, Maryland.

18. Funeral director: Emory D. Bolden.
Address: Oakland, Md.

19. 10/9/45 (Date rec'd by registrar) Julia Bowman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8th 1945, at 6:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944, to October 1945 and that I last saw him alive on October 7 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Arteriosclerosis	
Prostatic Hypertrophy	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. L. Baumgartner M. D. M. D. or other
Address: Oakland Md. Date signed: 10/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B5a)

CERTIFICATE OF DEATH

10140 / 166

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Oakland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Oakland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Miss Marian Roberta White

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 9th, 1871

8. AGE: Years	Months	Days	If less than one day
74	9	2	..... hrs. ..... min.

9. Birthplace: Garrett County, Md.
(Town, county, and state)
10. Usual occupation: Retired Dress Maker.
11. Industry or business

FATHER
12. Name: Rowan White,
13. Birthplace: Garrett County, Md.

MOTHER
14. Maiden name: Margaret Waltz.
15. Birthplace: Garrett County, Md.

16. Informant: Mrs. Margaret Rodeheaver.
Address: Oakland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct 15th/45
(month) (day) (year)
Cemetery or crematory: Oakland Cemetery.
Location: Oakland, Md.

18. Funeral director: Isaac D. Golden
Address: Oakland, Md.

19. 10/14/45
(Date rec'd by registrar)
Julia Rowan
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11th, 1945, 8:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-7-44, 19.., to 10-11-45, 19.., and that I last saw her alive on 10-10-45, 19..

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other conditions: Arthritis Deformans	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Edward E. Boyd M.D.
M. D. or other
Address: Oakland, Maryland Date signed: 10-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10141

Reg. Diat. No. 166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Several Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Oakland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Almeda Catherine Yost.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John C. Yost
Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 11th, 1859

8. AGE: Years	Months	Days	If less than one day
86	10	3	..... hrs. ..... min.

9. Birthplace: Cranesville, W. Va.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: John G. Sines.
13. Birthplace: Cranesville, W. Va.
MOTHER 14. Maiden name: Lucinda Wilhelm.
15. Birthplace: Cranesville, W. Va.
16. Informant: Miss May Yost.
Address: Oakland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10th/45 (month) (day) (year)
Cemetery or crematory: Ashby Cemetery.
Location: Near Crellin, Md.
18. Funeral director: Murray S. Baldwin
Address: Oakland, Md.
19. 10 8 1945 (Date rec'd by registrar) Julia Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7th 1945, at 8:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1943 to October 1945 and that I last saw h.. alive on October 5 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Acute Toxemia	
Due to: Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. D. Baumgartner M. D. M. D. or other
Address: Oakland Md. Date signed: 10/9/45